

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

WILLARD L. SLOAN, EUGENE J.
WINNINGHAM, and JAMES L. KELLEY,
on behalf of themselves and a similarly
situated class,

Plaintiffs,

Case No. 09-cv-10918
Hon. Paul D. Borman
Magistrate Mona K. Majzoub

v.

Class Action

BORGWARNER, INC., BORGWARNER
FLEXIBLE BENEFITS PLANS and
BORGWARNER DIVERSIFIED
TRANSMISSION PRODUCTS, INC.,

Defendants.

EXHIBIT 8

TO

**PLAINTIFFS' MOTION
FOR SUMMARY JUDGMENT
AS TO LIABILITY**



**BorgWarner
Automotive**



**BORG-WARNER AUTOMOTIVE DIVERSIFIED
TRANSMISSION PRODUCTS CORPORATION,
MUNCIE PLANT
&
LOCAL 287, UAW
INSURANCE HIGHLIGHTS
OF THE 1998 CONTRACT NEGOTIATIONS**

This Summary is an outline of the types and benefit level of coverage negotiated between Borg-Warner Automotive Diversified Transmission Products Corporation, the International Union, United Automobile, Aerospace and Agricultural Implement Workers of America, UAW and its Local Union Number 287. The details and provisions of the Health Insurance Agreement (the "Plan") will govern all coverage or exclusion provisions.

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DISCLAIMER NOTICE

The following is a very brief description of health benefits offered to hourly employees of Borg-Warner Automotive Diversified Transmission Products Corporation, Muncie Plant (the "Company"). For further details, you may refer to the official plan documents (including the Health Insurance Agreement) which describe the provisions in more detail and solely govern with respect to your eligibility and participation in the health plan of the Company.

The Company & Union may through the process of negotiations, modify, amend, suspend, or terminate these plans in whole or in part. Nothing herein, except as spelled out in the Company & Union Contract, shall be construed or interpreted to constitute an employment contract between the Company and any individual employee. The details and provisions of the Health Insurance Agreement (the "Plan") will govern all coverages or exclusion provisions.

DTP001144

A. SUMMARY OF THE 1998 INSURANCE CHANGES:

1. FOR ACTIVE EMPLOYEES ONLY:

LIFE INSURANCE:

Increases 3/12/98 TO \$28,500

Increases 4/1/99 TO \$29,000

Increases 4/1/2000 TO \$29,500

(Note, those who are eligible to retire (30&Out, 85 Points or age 60 with 10 or more years) on or after 3/12/98 would keep the amount of Life insurance in effect immediately prior to the retirement date until age 65, then the amount would reduce to \$7,000 thereafter)

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Increases 3/12/98 TO \$26,500

Increases 4/1/99 TO \$27,000

Increases 4/1/2000 TO \$27,500

VOLUNTARY GROUP UNIVERSAL LIFE

For those who wish to supplement the company provided employee life coverage; remains unchanged

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) COVERAGE

For those who wish to supplement the company provided AD&D; remains unchanged

WEEKLY ACCIDENT & SICKNESS DISABILITY BENEFIT

(For new claims incurred on/after 4/1/98, 4/1/99 & 4/1/2000----these claims will continue to be processed In-house by the Company.) Increases 4/1/98 to \$289, Increases 4/1/99 to \$294 and Increases 4/1/2000 to \$300

TRANSITION & BRIDGE BENEFIT:

For new claims incurred on/after 3/12/98 the Maximum benefit level becomes \$500. The Minimum remains at \$225.

EXTENDED DISABILITY BENEFIT:

For those employees with 10 or more years of service, who are covered by the retirement saving plan (RSP), the monthly extended disability benefit (EDB) schedule Level remains at 60% of the base wage. The EDB benefit table includes the highest wage rate during this contract.

GENERAL REQUIREMENTS REGARDING BENEFIT INCREASES:

In each active employee case mentioned above, the increase in benefit level requires that the employee be actively at work on or after the effective date to receive the higher level of benefits. For the Weekly Accident & Sickness Disability Benefit (A&S) and the Extended Disability Benefit (EDB) the increased benefit levels are only effective for new disabilities incurred on or after the effective date of the benefit changes.

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2. FOR ACTIVE EMPLOYEES, RETIREES & SURVIVORS:

Modifications To Improve The Rx Drug Plan For All Active Employees, Current Retirees, Future Retirees And Survivors Effective 7/1/98.

Expanded list of Pharmacy "Providers":

Each employee/retiree gets his/her own listing of participating Pharmacies within a 7-mile radius of their home along with their new Rx Drug card.

At this time, there are seven chemically equivalent drugs on the Preferred Medication Formulary that are required under the program. Those chemically equivalent drugs are medications selected on the basis of their quality and cost. Chemically equivalent means they are drugs that have the same chemical composition and medical effect. They contain equal amounts of the same active ingredients, in the same dosage. The only difference is in the size, shape and color of the medication.

The Mail Order Program will no longer require mandatory Mail Order after the 68th day, but it is still encouraged since you can receive up to a 90 day supply for one copayment.

The Rx Drug Plan copayment amounts for Actives (including those retirees who voluntarily elected to participate in the "PPO" program, or their eligible survivors) & all future Retirees/Survivors Increases 7/1/98 by \$2.00; Generic Rx copays become \$7.00/script and Brand Named Rx copays become \$12.00 per prescription obtained at a pharmacy.

No change to the Rx Drug copayments for retirees who retired before 11/2/89 or those who retired after 11/2/89 and before 3/11/95 who are not participants under the PPO Health Plan.

You should have received information from Express Scripts'-Value Rx, inc., with details of the Program & your new Rx drug card (they are paper cards this time, not plastic).

MENTAL HEALTH & SUBSTANCE ABUSE FOR ALL ACTIVE EMPLOYEES, CURRENT RETIREES, FUTURE RETIREES AND SURVIVORS:

The Company & Union agreed to modify the MENTAL HEALTH & SUBSTANCE ABUSE program effective 5/1/98 to combine the Mental Health and the Substance Abuse benefits into one common Plan as follows:

INPATIENT:

Inpatient Hospital confinement for MENTAL HEALTH & SUBSTANCE ABUSE:

The Plan provides 30 days per calendar year & 60 days per Lifetime without dollar limits.

Benefits are still paid at 90% without a deductible. All of the other limitations and requirements such as Pre-Certification, EAP approval etc. still apply.

OUTPATIENT:

Outpatient TREATMENT for MENTAL HEALTH & SUBSTANCE ABUSE:

The Plan provides up to 20 visits per Calendar year, with a Lifetime Maximum of 40 visits without dollar limits.

Benefits are paid at 80% after the Major Medical Deductible has been satisfied. All of the other limitations and requirements such as Pre-approval by the EAP still apply.

You should contact the EAP representative (Jim Butler) in advance if such services are needed for you or a family member. The phone number is 765-286-6398.

PAST & FUTURE RETIREE LIFE INSURANCE:

Effective 3/12/98; for past retirees whose final life insurance amount is \$3,000 the final life insurance amount is increased to \$4,000. Those prior retirees with final life amounts of \$6,000 at age 65 increase to \$7,000. Future retirees will continue to receive the active life amount in effect immediately prior to their retirement date until age 65. At age 65 their final life amount will be \$7,000.

THE HEARING PPO REMAINS UNCHANGED. NOTE: retirees pay their own cost, but they can get same prices as charged for the PPO by showing their BWA "ID" at WILSON'S HEARING AID CENTER, 3716 N. Wheeling, Muncie, In.

THE CARDINAL HEALTH "HMO" PLAN CALLED "HEALTHPOINT" WILL BECOME OPTIONAL TO ACTIVES AND PERHAPS TO PRE-MEDICARE RETIREES SOME TIME IN THE FUTURE (THE EFFECTIVE DATE IS NOT YET AVAILABLE). Basically, the same primary care doctors who provide services under the "PPO" will be available under the "HMO". At the time the effective date is established, we will have more details about that "optional" health plan.

B. OVERVIEW OF THE INSURANCE PLAN--INCLUDING CHANGES THAT BECAME EFFECTIVE IN 1998:

The following is a very brief description of health benefits offered to full-time hourly employees of Borg-Warner Automotive Diversified Transmission Products Corporation, Muncie Plant (the "Company"). You may refer to the official plan documents (including the Health Insurance Agreement) which describe the provisions in more detail and solely govern with respect to your eligibility and participation in the health plan of the Company.

The Company & Union may through the process of negotiations, modify, amend, suspend, or terminate these plans in whole or in part. Nothing herein, except as spelled out in the Company & Union Contract, shall be construed or interpreted to constitute an employment contract between the Company and any individual employee.

HEALTH INSURANCE PLAN

An active employee will be considered a "New Employee" under the Plan for the period from the date of hire until the first day of the calendar month following completion of his/her third full month of Seniority in accordance with the Collective Bargaining Agreement. The New Employee and his/her dependents are eligible only for the coverages provided under the New Employee Benefit Program provisions set forth in Exhibit K of the Health Insurance Agreement.

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The Company's Health Insurance Program provides comprehensive medical coverage for the employee, eligible spouse and dependent children (to age 19 or to age 25 if full-time student). Our insurance carrier requires proof of dependency. Some highlights of the insurance program are:

Following the period of "New Employee" coverage mentioned above, active employees who live within the seven (7) County PPO Network Area who use the PPO providers are covered by the In-Network schedule listed below as long as they use Network providers. However, if they use non-Network providers, their benefits are provided per the "Out-Of-Network" schedules which provides lower benefit level with higher deductibles and stop-loss amounts. The PPO "Network" includes **Ball Memorial Hospital, Muncie**, Community Hospital-Anderson, Randolph County Hospital, Winchester, Blackford County Hospital, Hartford City & Henry County Hospital, New Castle; and Cardinal Health Alliance (was Eastern Indiana Health Partners, Inc.) for participating doctors in the seven County "AREA" (all Delaware County doctors). The "AREA" is the 6 Counties that touch Delaware County and Delaware County.

1. This Schedule applies to Active employees & to those Retirees covered by the PPO program:

<u>In-Network providers used</u>	<u>Description</u>	<u>Out-of-Network providers used</u>
90%, no deductible	Inpatient hospitalization	80%, no deductible
100%, no deductible	Outpatient benefits (O/P surgery, Lab/X-ray)	80%, no deductible
100%, no deductible Ded. (Preventive only covered In-Network)	Preventive: Mammograms, Pap Tests, Digital Prostate exam & Well Baby Immunizations	(non-preventive Tests-80%, no Exams-70%, with diagnosis, after Major Medical deductible)
80%, after deductible	Major Medical expenses	70%, after deductible
80%-no deductible	Hospice (Terminally Ill) (\$7,000 maximum) Outpatient coverage only	80%-no deductible
90% after deductible	Primary Care Drs, Pediatric & OB/GYN's included	70%, after deductible
\$168 Indv./\$504 Family* (Couple \$336)	Deductible: applies to Misc. & to "Primary Care" expenses	\$336 Indv./\$1,008 Family* (Couple \$672)
\$804 Indv./\$1,608 Family*	Stop-Loss Limits	\$1,608 Indv./\$3,216 Family*

"STOP-LOSS" is the maximum 10%, 20% or 30% which the covered individual must pay before the Plan pays 100% of covered expenses during a calendar year (limited to the maximums shown above). Your total "out-of-pocket expense" is the deductible where applicable plus the annual stop-loss amount.

* The 1998 Deductible & Stop-Loss amount are shown. Increases 5% each Jan.1 through year 2002.

(Note: All inpatient hospitalizations require Pre-Certification review by INTRACORP, our Utilization Review provider. Call 1-800-662-2273 before you enter the hospital - or within two business days for "Emergencies")

At this time, the Company will pay the entire premium cost of this plan for you and your eligible dependents while actively at work or on approved sick leave - up to the time limit specified in the Plan. PPO program retiree coverage is also currently provided as described above.

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2. This Schedule applies to Retirees who are NOT covered by the PPO program:

Percent Plan Pays	Description	
90%, no deductible	Inpatient hospitalization	
100%, no deductible	Outpatient benefits (O/P surgery, Lab/X-ray)	
100%, no deductible	Diagnostic X-ray & Lab Tests (no preventive coverage)	
80%, after deductible	Major Medical expenses	
90% after deductible	Primary Care Drs, Pediatric & OB/GYN's included	(only If M.D. is in the PPO)

MAJOR MEDICAL DEDUCTIBLES for Retirees:

Those retired prior to 11/2/89: **As of 1/1/1998:**
\$125 per person per calendar year.

Those retired after 11/2/89 and before 3/11/95, who did not elect the PPO Plan: \$200 per person per calendar year.

STOP-LOSS LIMIT Amounts for Retirees:**PRE-MEDICARE:**

Pre-Medicare Stop-Loss for those retired prior to 11/2/89: \$300 per Individual & \$600 per Family.

Pre-Medicare Stop-Loss for those retired after 11/2/89 and before 3/11/95, who elected not to participate in the PPO program: \$600 per Individual & \$1,200 per Family.

MEDICARE:

Medicare Stop-Loss for those retired prior to 11/2/89: \$175 per Individual & \$350 per Family.

Medicare Stop-Loss for those retired after 11/2/89 and before 3/11/95, who elected not to participate in the PPO program: \$450 per Individual & \$900 per Family.

"STOP-LOSS" is the maximum 10% or 20%, which the covered individual must pay before the Plan pays 100% of covered expenses during a calendar year (limited to the maximums shown above). Your total "out-of-pocket expense" is the deductible where applicable plus the annual stop-loss amount.

(Note: All Pre-Medicare Retiree's inpatient hospitalizations require Pre-Certification review by INTRACORP, our Utilization Review provider. Call 1-800-662-2273 before you enter the hospital - or within two business days for "Emergencies")

At this time, the Company will pay the entire premium cost of this plan for you and your eligible dependents. Certain Survivors must pay premiums to continue the Insurance coverages.

OTHER IMPORTANT HEALTH CARE PROVISIONS

Working Spouse Provision: If an employee's spouse is eligible for coverage under a group health, prescription drug, organ or tissue transplant benefit offered by his/her employer and the employer pays a portion of the Plans cost, such spouse must enroll in his/her employer's coverage in order to be eligible for coverage as an eligible dependent under this Health Care Plan. This does not apply for "Retirees".

Special Enrollment Periods: Under Federal law, a group health plan must provide two special enrollment periods for employees and dependents. The first type of special enrollment period is available to any employee or dependent who has had other coverage that he loses, if he meets four conditions: (1) the individual had other coverage at the time he became eligible for the plan; (2) the individual declined in writing to enroll in the plan because he had other coverage; (3) coverage being lost was COBRA coverage that was exhausted, other coverage for which the individual is no longer eligible (for example, by reason of divorce from, or termination of employment of the spouse), or the employer providing other coverage ceased to pay for it; and (4) the individual requests enrollment under the group health plan within 30 days after losing the other coverage. Coverage under this type of special enrollment becomes effective no later than the first of the month after the request for enrollment.

The second special enrollment period applies when an employee who is a participant or is eligible to participate in a group health plan marries, has a child, adopts a child, or has a child placed for adoption. The special enrollment period in this circumstance must extend for at least 30 days beginning on the date of marriage, birth, adoption, or placement for adoption. During this special enrollment period, not only the new dependent, but also the employee and the employee's spouse may enroll. If the new dependent is enrolled within 30 days of the start of the special enrollment period, the coverage becomes effective as of the birth, adoption, or placement for adoption or, for marriage, no later than the first of the month after the request for enrollment.

Mental & Substance Abuse Expenses require Pre-Approval by the Employee Assistance Coordinator. Contact Jim Butler at 286-6398 for approvals. This does apply for Active employees and Retirees.

Miscellaneous Medical Benefits:

In-hospital Medical, Physician Visits, Bedside Consultation, Prolonged Attendance, Medical Emergency, Outpatient Diagnostic X-ray & Lab, Physical Therapy, Radiation Therapy, Exam of Newborn and Preventive. Also, Convalescent & Long-Term Illness, Chemotherapy, Hospice and Psychiatric Care/Substance coverage's. Details are in the Health Insurance Agreement. This does apply for Active employees and Retirees --- except that Retirees do not have "Preventive" or "Hospice" coverages.

Maternity Benefits: Group health plans and health insurance issuers offering group health insurance coverage generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from a plan or insurance issuer for prescribing a length of stay not in excess of the above period.

PRESCRIPTION DRUG PROGRAM

Express Scripts-Value Rx, Inc., is the Administrator for our Prescription Drug program. Prescriptions may be obtained through participating retail pharmacies or Mail Service. This does apply for Active employees and all covered Retirees.

For questions call 1-800-625-6070.

ELIGIBILITY: Following "New Hire Plan" after completion of the 6th full month following date Seniority was gained.

COVERAGE: Requires the Mandatory first use of A-rated generic drugs.

CO-PAYMENTS FOR COVERED ACTIVE EMPLOYEES & PPO COVERED RETIREES:

(For the copayment amounts applicable to non-PPO covered retirees see section "C." Condensed outline of Benefits)

Pharmacy purchases: Effective 7/1/98 copayments are \$7/script for generic drugs.

Pharmacy purchases: Effective 7/1/98 copayments are \$12/script for brand name drugs

Mail order purchases for Active employees and Retirees/Survivors who are participants of the PPO Health Program:

Require a \$3 copayment/script for generic drugs and, require a \$4 copayment/script for the brand name drug when no A-rated generic drug is available or when your doctor has stated that a Medical Necessity required the brand (DAW presupposes Medical Necessity). When you requested the brand drug and a generic is available, you pay the difference between the cost of the generic and brand name drug plus the copayment.

The following does apply for Active employees and all Retirees:

Note: As of 7/1/98 the use of Mail Order for Rx's becomes Optional.

Mail Order should be used for Maintenance Drugs (long-term medications--up to a 90-day supply). When using the Mail Order Service, you should allow two weeks time to receive your mail order prescriptions.

Effective 7/1/98, there are seven chemically equivalent drugs on the Preferred Medication Formulary that are required under the program. Chemically equivalent drugs are medications selected on the basis of their quality and cost. Chemically equivalent means they are drugs that have the same chemical composition and medical effect. They contain equal amounts of the same active ingredients, in the same dosage. The only difference is in the size, shape and color of the medication.

There is also an expanded list of participating pharmacies. You will receive a list of pharmacies within a 7-mile radius of your home along with your new Rx Drug card (note! New Rx cards are paper cards, not plastic cards). Higher out-of-pocket cost may apply if a participating pharmacy is not used. Purchases from non-participating pharmacies require a direct reimbursement form. Payments are based on network level and the employee pays differences plus \$2.25/claim for such purchases, after the appropriate copayment.

Certain Rx Drug copays do not count towards Major Medical Plan deductibles or stop-loss.

DENTAL AND VISION PLANS

ELIGIBILITY: Following "New Hire Plan" (after completion of the 12th full month of Seniority).

Dental Benefits (Active employees only)

The Dental Plan pays:

- A. **DIAGNOSTIC, PREVENTIVE, and PALLIATIVE**
100% of the reasonable and customary charge for diagnostic, preventive and palliative expenses (routine oral exam-twice per year; scaling & cleaning; dental x-rays; and topical fluoride application);
- B. **RESTORATIVE, PERIODONTICS, ENDODONTICS, and ORAL SURGERY**
80% of the reasonable and customary charge (after the deductible) for restorative, periodontics, and oral surgery expenses (fillings & restorations; repair or re-cementing crowns, inlays, onlays, bridgework or dentures; relining or rebasing dentures; treatment of periodontal and other gum diseases, root canal, extractions);

- C. **PROSTHODONTIC**
50% of the reasonable and customary charge (after the deductibles) for prosthodontics installation of fixed bridgework, initial installation of full or partial dentures, replacements of existing dentures or bridgework; and
- D. **ORTHODONTIC**
50% of the reasonable and customary charge (after the deductible) for orthodontics...
- E. **COSMETIC BONDING TREATMENT FOR A CHILD UNDER AGE 19** (not subject to the deductible amount).

Maximum plan payments:

Calendar year Plan maximum
 - \$1,100 per individual
 - \$4,400 per family
 Lifetime Orthodontic maximum \$1,200 per individual
 Lifetime TMJ maximum \$1,000 per individual
 Lifetime Periodontal maximum is \$1,450 per individual

Your calendar year deductible for combined (B), (C), and (D) expenses is **\$25 per individual and a limit of four individual deductibles per family**. Dental Plan deductibles and co-payments do not count toward the Health Care Plan deductibles and stop-losses.

VISION BENEFITS**Vision Benefits**

The *Vision Plan* pays up to:

<u>Type of Expense</u>	<u>ACTIVES</u>	<u>RETIRES</u>
	<u>Maximum Amount</u>	<u>Maximum Amount</u>
Complete Exam	\$37.50	\$30.00
Frames	\$50.00	\$40.00
Lenses:		
Single Lens	\$47.50/pair	\$45.00/pair
Bifocal	\$65.00/pair	\$55.00/pair
Trifocal	\$85.00/pair	\$65.00/pair
Contact Lens	\$60.00/pair	\$45.00/pair
Contact Lens (Medically Prescribed)	\$95.00/pair	\$75.00/pair

"Frames" Benefit is limited to **once every two calendar years**, unless written medical documentation certifies new "frames" are required due to a change in the prescription. Exams **each calendar year** and new lens **each calendar year** if written medical documentation certifies new "Lens" are required due to a change in the prescription.

LIFE INSURANCE: NON-CONTRIBUTORY (APPLIES ONLY TO ACTIVE EMPLOYEES)

ELIGIBILITY: Following "New Hire Plan" (after completion of the 3rd full month following the date Seniority was gained).

BASIC LIFE COVERAGE: \$28,500., effective March 12, 1998. (4/1/99 increases to \$29,000 & 4/1/2000 the amount increases to \$29,500. Each change requires being actively at work status).

DEPENDENT GROUP LIFE INSURANCE: OPTIONAL AMOUNT IS EMPLOYEE PAID
(APPLIES ONLY TO ACTIVE EMPLOYEES)

An employee's spouse and/or children are eligible for Dependent Life Insurance. Two (2) Dependent Term Life Insurance options are available.

Dependent Life Insurance coverage for spouse and/or children is provided in the amount of \$5,000. Option for an additional \$5,000 (or \$10,000 total). The current monthly employee contributions is \$1.60 for the Optional \$5,000. Payable through payroll deductions.

OPTIONAL GROUP UNIVERSAL LIFE (GUL): EMPLOYEE PAID
(APPLIES ONLY TO ACTIVE EMPLOYEES)

ELIGIBILITY: Following "New Hire Plan".

Employees use payroll deduction for premium payment. Employees may choose coverage in the amount of one, two, three or four times your base annual salary. Minimum is \$10,000 & Maximum is \$1,000,000.

For an employee's spouse and/or children. Spouse: \$10,000, \$25,000 or \$50,000.

Dependent Children: \$5,000 or \$10,000.

ACCIDENTAL DEATH & DISMEMBERMENT: NON-CONTRIBUTORY
(APPLIES ONLY TO ACTIVE EMPLOYEES)

ELIGIBILITY: Following "New Hire Plan".

COVERAGE: \$26,500, effective March 12, 1998. (4/1/99 increases to \$27,000 & 4/1/2000 the amount increases to \$27,500. Each change requires being actively at work status).

VOLUNTARY GROUP ACCIDENT: EMPLOYEE PAID (APPLIES ONLY TO ACTIVE EMPLOYEES)

The coverage is a separate Plan, Insured with Bankers Life & Casualty Co. Worldwide coverage on a 24 - hour basis for accidents occurring at home or elsewhere and whether engaged in business or pleasure. There are certain exclusions that apply.

ELIGIBILITY: Following "New Hire Plan".

COVERAGE OPTIONS:

From \$10,000 - \$100,000 at a minimal cost. For employee or for employee & family.

TRANSITION & BRIDGE BENEFIT: NON-CONTRIBUTORY

(APPLIES TO ACTIVE EMPLOYEES & TOTAL & PERMANENT DISABILITY RETIREES HAVE COVERAGE PRIOR TO AGE 65, BASED ON THE BENEFIT LEVEL IN EFFECT WHEN THEY RETIRED)

Transition & Bridge benefit is a form of life insurance paid-out in monthly installments following death. The maximum monthly amount is \$500 (new claims on/after 3/12/98) (In certain circumstances where the survivor is covered for unreduced benefits under the Federal Social Security Act a lower amount of \$225 per month is applicable). The Transition portion is payable for 24 months. For those Survivors eligible for Bridge, the payment following the Bridge portion could continue until age 62 (or re-marriage). See Plan for details and eligibility.

DISABILITY INCOME PLAN: NON-CONTRIBUTORY (APPLIES ONLY TO ACTIVE EMPLOYEES)

WEEKLY ACCIDENT & SICKNESS DISABILITY BENEFITS:

(NON-OCCUPATIONAL DISABILITY)

ELIGIBILITY: The first of the month following the date the employee gained his/her Seniority a lower level of benefits applies to new claims on/after each of the following:

First of the month following date Seniority was gained, the weekly disability benefit rate is \$100/week, then first of 4th month the weekly disability benefit rate becomes \$110/week, then first of 7th month the weekly disability benefit amount becomes \$120/week.

A 26 week maximum (over an 18 month time period) applies during the period prior to the first of the 13th month following date Seniority was gained.

Following the Special New Hire Disability Benefit Plan mentioned above, (effective 1st of the 13th month following the date Seniority was gained), employees begin to receive the benefit levels below and the maximum benefit period becomes 52 weeks over an 18-month period.

COVERAGE: (Following the 12th full month of Seniority)

WEEKLY ACCIDENT & SICKNESS DISABILITY BENEFITS: \$289 per week (April 1, 1998 amount), (4/1/99 the rate increases to \$294 & 4/1/2000 the amount increases to \$300. Each benefit rate change applies only to new claims incurred on/after the effective date of such change for documented disabilities following the required waiting period). Also requires completion of a Disability Claim Form with doctor's medical statement. Must be actively at work for each benefit rate change to become effective.

Benefits are integrated with Extended Disability (EDB) for those employees who are covered for EDB and with Disability Social Security. The Maximum duration is calculated over a consecutive eighteen-(18) month period.

EXTENDED DISABILITY PLAN (ONLY APPLIES TO ACTIVE EMPLOYEES WHO ARE PARTICIPATING IN THE MUNCIE RETIREMENT SAVINGS PLAN):

Requires 10 years of service, a six-(6) month waiting period and total disability.

LEVELS OF LONG-TERM DISABILITY BENEFITS ARE REFLECTED ON THE EDB SCHEDULE: Benefits are integrated with Social Security and Railroad Retirement.

DURATION OF BENEFITS: Depends on age at date of disability--see EDB reference in the Health Insurance Agreement booklet for full details of the plan. (Length of Service at date of disability but not beyond age 65 if disabled before age 60 or a decreasing schedule based on age at date of disability if disabled on or after age 60)

(the following pages reflect broad category of Health benefits for Actives)

C. CONDENSED VIEWS OF THE BENEFITS & CATEGORIES THAT FALL UNDER THE PLAN.

1. HOURLY ACTIVE EMPLOYEES & PPO COVERED

RETIREEES 1998 CURRENT INSURANCE REVIEW: ONLY IN-NETWORK SCHEDULE IS REFLECTED BELOW (also see page 6 & 7 to see Out-of-Network schedules)

BASE

Inpatient Paid @ 90%

Hosp. Room & Board (**DRG's @ Ball Hosp**)*

Hospital Additional (**DRG's @ Ball Hosp**)*

*Approved referral @ 90% U&C if not a PPO Hosp. & not in PPO Plan

Inpatient Consultation

Radiology (x-ray)

Pathology (lab)

Major Medical 1/98:

\$168 Individual/\$336 Couple/\$504 Family Deductibles, Co-payment @ 80% U & C or @ 90% for **PRIMARY CARE PHYSICIANS* ONLY.**

*Primary Care Drs. are G.P.'s, Pediatric & Internists & OB/GYN's.

Occupational Therapy

Physicians (PPO fee schedule applies):

Inpatient Anesthesia
 Inpatient Surgery
 Inpatient Doctors Visits
 Hosp. Emergency Physician
 Hosp. Emergency Room - Accident
 Hosp. Emergency Physician
 Hosp. Emergency Room - Acute Illness
 Convalescent & Long Term Disability
 (Skilled Nursing Home)

80% - No Deductible

Hospice, outpatient: \$7000 Max.(Actives)

Outpatient Physical Therapy

Outpatient - 100% U&C

Chemotherapy

Surgery - Hospital (ASC's @ Ball Hosp)

Surgery - Doctor

Diagnostic X-ray

Per Schedules are:

Radiation Therapy (Per Schedule)

Hearing Plan-50% over 36 mos(+1 yr.serv)

Ambulance to/from hospital - per schedule:

Within City up to \$75, within 50 mile radius up

To \$125, over 50 mile radius up to \$175. Air

**Ambulance if billed by hospital & considered as
 Medically Necessary.**

Dental Plan-\$25 Deductible(Family \$100),

100%Preventive, 80% repairs, 50% Bridges &

Periodontal (+1yr service) Annual & Lifetime Max.

Substance Abuse Treatment & all

**Psychiatric care still requires Mandatory
 after**

**Pre-approval: call Jim Butler @ 286-3398
 for the required prior "Approval".!**

Change effective 5/1/98 Psychiatric Benefits

& Substance Abuse was combined. Inpatient:

90% for 30 days Yr /60 per Lifetime, no ded.

(3/12/98) Outpatient: 80%,20 visits Yr/40

per Life payable after Major Medical Ded.

Accident & Sickness Disability

\$289 Wk. (eff. 4/1/98), also incr's. 4/99 & 4/2000

Dependent Group Life is either \$5,000

Company paid, or \$10,000 with employee contr's.

Office Call Exam. Consultation

Speech Therapy (qualified Diagnosis)

Diagnostic Lab Procedures

Chiropractor Services

Inhalation Therapy

Kidney Dialysis

Hospital Beds

Wheel Chairs

Medical Supplies

Braces

Prosthesis

Oxygen/Equipment

Nursing Service:

In Hospital R.N. or L.P.N.'s

In Home - R.N. only

Utilization Review-All Inpatients must call

Intracorp for approval prior to Hospitalizations.

1-800-662-2273 (except for Medicare)

Prescription Drugs Mandatory Generics

\$12 for Brand & \$7 for Generic "Retail"

or if Mail Order pay \$4 for Brand & \$3 Generic

Rx's. 7/1/98 Mail Order is Optional choice.

Maintenance drugs can go via Mail Order Plan.

There is an Excluded "List" of certain Brand

drugs that do not require Class A Generics.

Transition/Bridge is \$500 Max. (4/1/98).

Vision Plan - Per Schedule (+1 yr. service)

STOP-LOSS MAXIMUMS - Plan pays @100%

\$804 Per Person Stop Loss & \$1608 (1/98)

per family for that calendar year.

Active Life insurance is \$28,500 (eff. 3/12/98)

Accidental Death & Dismemberment is \$26,500

As of 3/12/98.-- Incr's + \$500 4/99 & 4/2000 .

PREVENTIVE @100% per schedules:

Mamograms, Pap, Well Baby Immunizations

& Prostate DIGITAL exams.

Delaware Co. Drs. considered In-Network, but employees do not get "Fee Sch." & could get "balance billed" if not PPO Drs. OUT-OF-NETWORK SCHEDULES APPLY IF ACTIVE EMPLOYEE LIVES IN AREA, BUT DOES NOT USE PPO.

(Below is the outline for Retirees & Survivors)

2. **HOURLY RETIREE HEALTH INSURANCE OUTLINE** **1998 CURRENT INSURANCE REVIEW (those not in PPO)**

BASE

Inpatient - 90%

Hosp. Rm & Brd & Addit's
@90% of Reasonable & Customary

Radiology (x-ray)
Anesthesia
Surgery
Doctors Visits
Consultation

Hosp. Emergency Room - Accident
Hosp. Emergency Physician
Hosp. Emergency Room - Acute Illness
Hosp. Emergency Physician
Convalescent & Long Term Disability
(Skilled Nursing Home)

Pathology (lab)

Outpatient - 100% U&C

Chemotherapy
Surgery - Hospital (ASC's @Ball Hosp)
Surgery - Doctor
Diagnostic X-ray

Radiation Therapy - Per Schedule

Ambulance to/from hospital - per schedule:

Within City up to \$50, within 50 mile radius up
To \$100, over 50 mile radius up to \$150.

SUBSTANCE ABUSE TREATMENT **& ALL PSYCHIATRIC CARE**

REQUIRES MANDATORY

PRE-APPROVAL:

CALL Jim Butler @ 286-3398 for the required
"Approval"! Psychiatric Benefits & Substance
Abuse are now combined into one Plan.

Outpatient Physical Therapy:

80% - No Deductible for those Retirees
covered under the PPO Plan, but for those
retirees not under the PPO Plan the Annual
Major Medical Deductible does apply.

Major Medical

Deductibles vary (see schedule), Co-payment
@ 80% U & C or @90% for PPO PRIMARY
CARE PHYSICIANS *(Pre-Medicare only).

*Primary Care Drs. are PPO G.P.'s, Pediatric &
Internists

Occupational Therapy
Physicians (PPO fee schedule applies):

Office Call, Exam, Consultation

Chiropractor Services

Inhalation Therapy

Kidney Dialysis

Hospital Beds

Wheel Chairs

Medical Supplies

Braces

Prosthesis

Oxygen/Equipment

Nursing Service:

In Hospital R.N. or L.P.N.'s

In Home - R.N. only

Speech Therapy (qualified Diagnosis)

Diagnostic Lab Procedures

STOP-LOSS MAXIMUMS - Plan pays @100%
after required Co-payments are reached.

Utilization Review-All Inpatients must call
Intracorp for approval prior to Hospitalization. **CALL**
1-800-662-2273 -- Does not apply to those retirees on
"Medicare "!

*(A schedule of Retiree/Survivor Major Medical Deductibles
and Stop-Loss Limits is reflected separately since the
amounts depend on the date of retirement and Plan
applicable)*

MAJOR MEDICAL DEDUCTIBLES for Retirees:

As of 1/1/1998:

Those retired prior to 11/2/89:	\$125 per person per calendar year.
Those retired after 11/2/89 and before 3/11/95, who did not elect the PPO Plan:	\$200 per person per calendar year.
Those retired after 11/2/89 and before 3/11/95, who elected to Participate in the PPO Plan: deductibles as "Active Employees")	\$168 Individual, \$336 Couple & (same \$504 Family (Incr.+5% per Yr.)
Those who retired after 3/11/95:	\$168 Individual, \$336 Couple & \$504 Family (Incr.+5% per Yr.)

STOP-LOSS LIMIT AMOUNTS for Retirees:**PRE-MEDICARE:**

Pre-Medicare Stop-Loss for those retired prior to 11/2/89: \$300 per Individual & \$600 per Family.

Pre-Medicare Stop-Loss for those retired after 11/2/89 and before 3/11/95, who elected not to participate in the PPO program: \$600 per Individual & \$1,200 per Family.

Those who retired after 3/11/95: \$804 per Individual & \$1,608 family (Incr.+5% per Yr.)

MEDICARE:

Medicare Stop-Loss for those retired prior to 11/2/89: \$175 per Individual & \$350 per Family.

Medicare Stop-Loss for those retired after 11/2/89 and before 3/11/95, who elected not to participate in the PPO program: \$450 per Individual & \$900 per Family.

Medicare Stop-Loss for those retired after 11/2/89 & prior to 3/11/95, & who elected to participate in the PPO program. (same as for "Active Employees".) \$804 per Individual & \$1,608 family (Incr.+5% per Yr.)

Those who retired after 3/11/95: \$804 per Individual & \$1,608 family (Incr.+5% per Yr.)

PRESCRIPTION DRUG PLAN DEDUCTIBLES & CHANGES FOR RETIREES:

- Expanded list of Pharmacy "Providers":
- Each retiree/survivor gets his/her own listing of participating Pharmacies within a 7-mile radius of their home along with their new Rx Drug card.
- At this time, there are seven chemically equivalent drugs on the Preferred Medication Formulary that are required under the program. Those chemically equivalent drugs are medications selected on the basis of their quality and cost. Chemically equivalent means they are drugs that have the same chemical composition and medical effect. They contain equal amounts of the same active ingredients, in the same dosage. The only difference is in the size, shape and color of the medication..
- The Mail Order Program will no longer require mandatory Mail Order after the 68th day, but it is still encouraged since you can receive up to a 90 day supply for one deductible.

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RX DRUG DEDUCTIBLES FOR RETIREES/SURVIVORS:

For those retired prior to 10/1/86:

@ Retail Pharmacies, Brand Copay is \$3 & \$2 Copay for Generics. Mail Order Copays are \$2 for Brand or Generic prescriptions.

For those retired after 10/1/86 and before 11/2/89 who are not a PPO Plan Participant:

@ Retail Pharmacies, Brand Copay is \$4 & \$2 Copay for Generics. Mail Order Copays are \$2 for Brand or Generic prescriptions.

For those retired after 11/2/89 who are not a PPO Plan Participant:

@ Retail Pharmacy Brand Copay is \$7 & the Copay is \$4 for Generics. Mail Order Copays are \$2 for Brand or Generics.

For those retired after 11/2/89 who are Participants in the PPO Plan: (same as "Active Employees") @ Retail Pharmacy Brand Copay is \$12 & the Copay is \$7 for Generics. Mail Order Copays are \$4 for Brand Rx's & \$3 for Generic Rx's.

For questions about Rx Drugs call 1-800-625-6070!

OTHER FACTS

INTRODUCTION: THIS SECTION PROVIDES INFORMATION WITH RESPECT TO ADMINISTRATION, WHO THE TRUSTEE AND INSURANCE COMPANIES ARE AND INFORMATION ABOUT YOUR RIGHTS UNDER COBRA AND ERISA.

PLAN SPONSOR: The sponsor of the Borg-Warner Automotive Diversified Transmission Products Corporation, Muncie Plant Group Insurance Plan for Hourly Employees is:

Borg-Warner Automotive Diversified
Transmission Products Corporation,
Muncie Plant
5401 Kilgore Avenue, Muncie, IN 47304-4717
Telephone: 765-286-6455

INSURANCE INFORMATION:

Connecticut General Life Insurance Co., a CIGNA company ("Connecticut General" or Insurance Company) has entered into Group Insurance Policies for the benefits described in the Group Insurance Plan. The Group Insurance Policies specify the time when and the circumstances under which Connecticut General is liable for such benefits.

The address of the Insurance Company's Claims Office is:

Connecticut General Life Insurance Co., a CIGNA company
CIGNA HealthCare Service Center
P.O. Box 9317
Des Moines, IA 50306-9317

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THE PLAN ADMINISTRATOR FOR THE PLAN IS:

Borg-Warner Automotive Diversified
Transmission Products Corporation,
Muncie Plant
5401 Kilgore Avenue, Muncie, IN 47304-4717
Telephone: 765-286-6455

Questions about your insurance policies should be directed to the Plan Administrator at the above address.

NOTIFICATION OF ADDRESS: It is your responsibility, or that of your Beneficiary, to keep the Plan Administrator informed of your mailing address and other information needed to pay benefits from the Plan.

FINANCIAL RECORDS: Financial records for Group Insurance Policies underwritten by Connecticut General are kept on a calendar year basis.

EMPLOYER IDENTIFICATION NUMBER: For government reporting purposes, the employer identification number for Borg-Warner Automotive Diversified Transmission Products Corporation is 31-1232404.

PLAN IDENTIFICATION NUMBER: The official Plan name and number is:
Borg-Warner Automotive Diversified Transmission Products Corporation, Muncie Plant Group Insurance Plan for Hourly Employees -- Plan Number 582.

The Plan name and number should be used in any formal correspondence relating to the Plan.

AGENT FOR SERVICE OF LEGAL PROCESS: Matters of a legal nature relating to the Plan should be addressed to our agent for service of legal process:

Vice President & General Manager
Borg-Warner Automotive Diversified
Transmission Products Corporation,
Muncie Plant
5401 Kilgore Avenue, Muncie, IN 47304
Telephone: 765-286-6275

Matters of a legal nature relating to the Insurance Policy may be directed to the Supervisory Official of the state Insurance department in the state in which you reside.

**PLAN MAINTAINED PURSUANT TO A
COLLECTIVE BARGAINING AGREEMENT**

This Plan is maintained pursuant to a Collective Bargaining Agreement and a Health Insurance Agreement between the Plan sponsor and the International Union, United Automobile, Aerospace and Agricultural Implement Workers of America, UAW and its Local Union Number 287.

Copies of the Collective Bargaining Agreement are available for employees to examine at the office of the Plan Administrator. The 1998 Collective Bargaining Agreement (Health Insurance Agreement) is being prepared, but is not yet available for review.

The Health Insurance Agreement requires approvals of all three parties (Company, International Union & Local #287, UAW) before distribution. The Plan benefits have been administered in accordance with the Agreement reached with the International Union & Local #287, UAW and no claim delays have been experienced by the employees due to the delay in final approval of the Health Insurance Agreement booklet.

PLAN FINANCING: The Group Insurance Policies that make up the Plan are classified as welfare benefit plans. The Insurance Company determines premium rates paid by the Company for such policies. Employee contributions for optional coverages are based on a negotiated rate. Borg-Warner Automotive Diversified Transmission Products Corporation, Muncie Plant pays all administrative costs of operating the Plan.

FUTURE OF THE PLAN: Although Borg-Warner Automotive Diversified Transmission Products Corporation, Muncie Plant expects and intends to continue the Plan indefinitely, it reserves the right, subject to the terms of any existing Collective Bargaining Agreement, if any, between the Company and Union, to modify, amend, suspend or terminate the Plan or the Group Policies in whole or in part, at any time, and for any reason by action of either its Board of Directors or a person designated by resolution of such Board of Directors.

An individual's insurance coverage terminates when that person is no longer eligible or when the Group Insurance Policies terminate, whichever happens first. Additional information regarding termination of insurance policies and individual insurance coverage is provided in the Health Insurance Agreement.

CLAIMING BENEFIT: When you know in advance that you or a dependent will be hospitalized or have other medical or dental services performed, remember to:

- . Ask your Physician about the appropriateness of outpatient care, pre-admission tests and other alternatives to Hospital confinements.
- . Ask your Plan Administrator to give you the appropriate claim form. Then take the form with you and ask the Physician or Hospital to complete it and return it to you promptly. Connecticut General (CIGNA HEALTHCARE), the Insurance Company has a toll-free telephone number 1-800-235-2840 for Plan Participants to check to see whether a particular service or facility will be covered by the Plan. Your Plan Administrator can also check to see whether a particular service or facility will be covered by the Plan.
- . Take your Health Plan I.D. card along when you or your dependents are being admitted to a Hospital. The card provides information, such as the Plan Number, that Hospitals require at the time of admission.

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. Remember to call the toll-free number for INTRACORP 1-800-662-2273 if your Physician recommends hospitalization to verify the appropriateness of the care recommended. This section does not apply to those individuals who are covered by the Federal Medicare program.

FILING A CLAIM: To claim benefits under the Plan, you must submit the following items to the Insurance Company on a claim form, which can be obtained from the Insurance Office:

- . a completed claim form, along with,
- . bills for services you are claiming, and
- . copies of explanations of benefit payments from other group plans and Medicare, when those plans are "primary" for the expense you are claiming under the Plan.

Be sure to keep copies of all the above items for your records. Only you and the Insurance Company will have copies of the explanations of benefit payments (EOB's) records you receive from Connecticut General (CIGNA).

To help prevent delays in processing your claims, check to see that:

- . Your claim form is complete,
- . the Health Plan number is included,
- . your social security number is included,
- . all questions have been answered, and
- . any bill you submit must contain all this information:
 - the patient's name,
 - diagnosis,
 - type of service performed or supplies received
 - the date of service, and where it was performed or received
 - the provider's phone number
 - the amount charged, and
 - prescription numbers and date of purchase for drug bills.
- . You know whether this Plan is "primary" or "secondary" when you or a dependent is insured by two or more insurance plans. (You can find this information under "Coordination of Benefits".) If this Plan is "secondary," send the claim to the primary plan for payment first; then, submit your claim under this Plan, along with a copy of the other plan's explanation of benefit payment to CIGNA. When dependent children are covered by two or more plans the normal determination of "primary" is determined by the parent whose birthday falls earliest in the year.

If you have any questions or need help completing the forms your Plan Administrator will provide assistance.

HOW CLAIMS ARE PAID: The Insurance Company will pay your claims as soon as they are satisfied that your expenses are covered by the Plan. Most claims are paid within a month. Benefits are paid to you, or to the provider of services if you have completed an "assignment of benefits".

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If you do not receive payment or a written notice of denial of your claim within 90 days, ask your Plan Administrator to investigate reasons for the delay in settlement.

INCORRECT CLAIM PAYMENTS: If a claim is not paid correctly (for any reason) an adjustment will be made. If your claim is underpaid, the additional benefit amount due you will be paid. If your claim is overpaid, the Insurance Company may recover from you the amount overpaid either in cash, or by reducing the amount of future benefit payments for you or a dependent.

APPEALING CLAIM DENIALS:

If an insurance claim that is filed on your behalf or on behalf of a dependent is denied in whole or in part and you don't agree with the reason for denial, you may write within 60 days of the date you were notified of the denial to the person at the Insurance Company who wrote to advise you of the denial. Your letter should state why you believe the claim shouldn't have been denied, and include any information, questions or comments you think are appropriate. You may also request a Union representative, appointed under Article V Section 1, to investigate and pursue your claim through the following steps.

Step 1:

The insurance representative shall have access to the records pertaining to the claim being investigated. Upon completion of the investigation, the Union insurance representative may

present the claim, pursuant to Article V, Section 3(b) of the Insurance Agreement, at the next regularly scheduled meeting of the Joint Insurance Committee in an effort to settle the dispute.

Step 2:

If the Joint Insurance Committee is unable to settle an unpaid claim, the Committee may, by a vote of two representatives, request a review of the claim by the Insurance Company. Such review must be requested within fifteen (15) days following the meeting of the Joint Insurance Committee at which the unpaid claim was discussed in Step 1 and within sixty (60) days from the date that the employee was notified of his/her denial. When a review by the Insurance Company is requested, the representatives requesting the review shall prepare a statement of the facts and specify the provisions of the Insurance Agreement or the Schedule of Certificate under which the claim and/or dispute arises. The other representatives on the Joint Insurance Committee shall, if they disagree in whole or in part with the statement of the dispute, submit their own version of the statement of the dispute. The statement or statements of dispute and the claim file shall be forwarded to the Insurance Company. The Insurance Company shall make a thorough and careful review of the claim and shall have the right to request any other information it deems necessary or desirable.

Step 3:

If specific questions of interpretation or application of the Insurance Agreement have not been satisfactorily resolved, either the Union representatives or the Company representatives to the Joint Insurance Committee may request a representative of the Insurance Company to attend a meeting of the Joint Insurance Committee. Such requests will not be honored more than once every six-(6) months. Prior to any such meeting an agenda shall be mutually agreed upon by the Joint Insurance Committee representatives and shall be forwarded to the Insurance Company at

least thirty (30) days in advance of the meeting. Only the issues listed on the agenda will be considered at the meeting.

You, and the Joint Insurance Committee if you requested Union assistance, shall receive written notice of the final decision and the reasons therefor from the Insurance Company within 60 days of the date your appeal is received by the person you wrote to. If special circumstances cause a delay, you'll be notified in writing within 60 days of the date your appeal is received. The notification will specify the date you can expect the final decision to be made. The Insurance Company's decision and the reasons therefor shall be final and binding.

CONTINUATION OF COVERAGE (CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 -"COBRA" COVERAGE)

If insurance coverage under the Plan ends for you or your eligible dependent(s) you should consult with the Plan Administrator to determine if COBRA coverage applies. Generally the persons entitled to COBRA coverage (a "COBRA Beneficiary") are the following:

- A. The former spouse or other eligible dependents of an employee who otherwise would lose coverage because of the employee's divorce or legal separation.
- B. An employee's spouse or other eligible dependents who would otherwise lose eligibility for coverage under the Plan due to the employee's termination or reduction in hours (other than an employee's loss of eligibility for coverage due to discharge for gross misconduct shown in connection with his/her employment).
- C. The eligible dependent(s) (including the spouse) of an employee if the employee dies or becomes entitled to Medicare coverage while covered by this Plan.
- D. The eligible dependent(s) who ceases to be covered as a dependent under the terms of the Plan.

In the event of an employee's death, separation from service, reduction in hours or Medicare entitlement, the Company must notify the COBRA Beneficiary within forty-four (44) days of the right to elect to continue the coverage.

In the event of divorce or legal separation of the employee and spouse or the ineligibility of a dependent child under the Plan, the employee or the COBRA Beneficiary has the responsibility of notifying the Company within sixty (60) days of that event. The Company, in turn, must notify the COBRA Beneficiary within fourteen (14) days of such notification.

If the terminated COBRA Beneficiary or, with respect to a minor, the parent or guardian of the terminated COBRA Beneficiary, elects to continue coverage under the Plan, the notice to the Company must be given within sixty (60) days of the date that coverage ends or the date that notice of continuation rights is given to the COBRA Beneficiary, whichever is later. The payment amount required for continuation coverage under the Plan may not exceed 102 percent of the cost to the Plan for a similarly situated COBRA Beneficiary. The COBRA Beneficiary may elect to pay the premium in monthly installments.

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The continuation coverage available to a COBRA Beneficiary described in A, C, or D above is for thirty-six (36) months. A COBRA Beneficiary may experience a second qualifying event under A, C and D during the continued coverage period. However, in no case will the continued coverage period be longer than thirty-six (36) months from the original qualifying event. The eighteen months may be extended to twenty-nine (29) months if a COBRA Beneficiary described is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time during the first sixty (60) days of COBRA continuation coverage. This eleven-month extension is available to all individuals who are COBRA Beneficiaries due to a termination or reduction in hours of employment. To benefit from this extension, a COBRA Beneficiary must notify the Company of the Social Security disability determination within sixty (60) days of the determination and before the end of the original 18-month period. The affected individual must also notify the Company within thirty (30) days of any final determination that the individual is no longer disabled.

The COBRA continuation of coverage will terminate if:

- the COBRA Beneficiary fails to make timely payments under the Plan;
- the COBRA Beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition the Beneficiary may have.
- the COBRA Beneficiary becomes entitled to Medicare benefits (however, dependents not eligible for Medicare may extend benefits up to a maximum of thirty-six (36) months from the date of the original qualifying event); or
- the Company ceases to offer the Plan altogether.

YOUR RIGHTS UNDER ERISA

As a participant in this Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

- Examine without charge (in your Plan Administrator's office) all Plan documents including the insurance contracts and trust agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain at a reasonable charge, copies of all Plan documents and other Plan information upon written request to the Plan Administrator.
- Receive a summary of the Plans' annual financial reports which the Company is required by law to furnish to each participant.

In addition, ERISA imposes duties upon fiduciaries--the people who are responsible for the operation of the Plan. Fiduciaries must act prudently and in the interest of the Plan participants and beneficiaries. No one may terminate you or discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan reviewed and your claim reconsidered.

Under ERISA there are steps you can take to enforce your rights. For instance, if you request materials from the Company and do not receive them within 30 days, you may file suit in a federal court. The court may require the Company to provide the materials, unless the materials

were not sent because of reasons beyond the control of the Company's Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If Plan fiduciaries misuse a plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay court costs and fees. If you lose, the court may order you to pay these costs and fees.

If you have questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Participation in the Plan does not give you the right to be retained in the employ of the Company, nor does it give you a right or claim to any benefit you have not earned under the terms of the Plan.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY a CIGNA COMPANY (called CG)

BOOKLET RIDER TO SUMMARY PLAN DESCRIPTION (SPD)

Policyholder: BORG-WARNER AUTOMOTIVE, INC.

Rider Eligibility: Each Employee eligible under the booklet

Policy No. All Applicable PPO and Indemnity Group Health care
Policies Under Borg-Warner Automotive, Inc.

Effective Date: January 1, 1998

If you are in active work on that day. If you are not at work for other than health related conditions, on the date you return to active work. If you are not insured for the benefits described in your booklet on that date, the effective date of this booklet rider will be the date you become insured.

This Booklet Rider is being issued in compliance with the Health Insurance Portability and Accountability Act of 1996, the Newborn's and Mother's Protection Act of 1996 and the Mental Health Parity Act of 1996.

This Booklet Rider forms a part of the SPD which was issued, or will be issued to you by The Company describing the benefits provided under the corresponding policy(ies). The provisions contained herein supersede any provisions in any previously issued booklet to the contrary. Future publications of the SPD will include the language included in this Booklet Rider unless subsequently revised. This booklet rider is subject to state regulatory approval.

When Insurance Begins/Becoming Insured

Any restriction of coverage for your dependents will not include such dependents being confined to a hospital.

The results of any requested medical examination will not prohibit an eligible person from becoming covered.

Exception to Late Enrollment Requirements

A person will not be considered a late enrollee when enrolling outside a designated enrollment period if: he had existing coverage, and he certified in writing, if applicable, that he declined coverage due to other available coverage; he lost prior coverage due to the employer's failure to pay premium, he no longer qualifies in an eligible class for prior coverage, or his prior coverage ends, including continuation coverage; and he enrolls for this coverage within 31 days after losing or exhausting prior coverage. Any applicable Pre-existing Condition limitation will apply, but will not be extended as for a late enrollee.

If you acquire a new dependent through marriage, birth, adoption or placement for adoption, you may enroll yourself and your dependents provided you request enrollment by the last day of the 31-day period which begins on the day of the event. Coverage will be effective for a spouse, at the same time your other medical coverage begins for that location after enrollment, and for a child, on the date of birth, adoption, or placement for adoption. Your Plan's Pre-existing Condition limitation will apply to you and your dependents upon enrollment, reduced by prior Creditable Coverage.

Pre-existing Condition Limitation

For your Plan's Pre-existing Condition limitation, the following provisions apply:

Covered Charges do not include charges for an injury or sickness or for a related condition that existed within twelve (12) months prior to the effective date of an Employee's or an Eligible Dependent's insurance. No payment will be made for expenses incurred for that pre-existing condition until that covered individual has been continuously covered for twelve (12) consecutive months under the Health Care Plan.

Extension for Late Enrollees

For plans which include a Pre-existing Condition limitation, the one-year period under (iii) above, will be increased to 18 months for a late enrollee.

Exceptions to Pre-existing Condition Limitation

Pregnancy, and genetic information (i.e. test results; pending a specific diagnosis) with no related treatment, will not be considered Pre-existing Conditions.

A newborn child, an adopted child, or a child placed for adoption before age 18 will not be subject to any Pre-existing Condition limitation if such child is covered within 31 days of birth, adoption or placement for adoption. Such waiver will apply only if fewer than 63 days elapse between coverage during a prior period of Creditable Coverage and coverage under this plan.

Credit for Coverage Under Prior Plan

If a person was previously covered under a plan which qualifies as Creditable Coverage, the following will apply, provided he notifies the employer of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this plan, exclusive of any waiting period.

The Company will reduce your Pre-existing Condition limitation period under this policy by the number of days of prior Creditable Coverage you had under a creditable health plan or policy, up to 12 months for a timely enrollee and 18 months for a late enrollee.

Certification of Prior Creditable Coverage

You must provide proof of your prior Creditable Coverage in order to reduce a Pre-existing Condition limitation period. You should submit proof of prior coverage with your enrollment material. Certification, or other proofs of coverage which need to be submitted outside the standard enrollment form process for any reason, may be sent directly to: Eligibility Services, CIGNA HealthCare, P.O. Box 9077, Melville, NY 11747-9077. You should contact the plan administrator or CIGNA Customer Service Representative if assistance is needed to obtain proof of prior

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Creditable Coverage. Once your prior coverage records are reviewed and credit is calculated, you will receive a notice of your remaining Pre-existing Condition limitation period.

Creditable Coverage

Creditable Coverage will include coverage under: a self-insured employer group health plan; individual or group health insurance plans; state or federal continuation coverage; individual or group health conversion plans; Part A or Part B of Medicare; Medicaid, except coverage solely for pediatric vaccines; the Indian Health Service; the Peace Corps Act; a state health benefits risk pool; a public health plan; health coverage for current and former members of the armed forces and their Dependents; medical savings accounts; and health insurance for federal employees and their Dependents.

ERISA (Effective June 1, 1997)

The following is added to the section of the certificate/document entitled "Summary Plan Description":

The Insurance Company will provide administrative services of the following nature; Claim Administration; Cost Containment; Financial; Banking and Billing Administration.

Benefits provided under this booklet are fully guaranteed by The Insurance Company.

This document is issued by:

Connecticut General Life Insurance Company

900 Cottage Grove Road

Hartford, CT 06152

If you have questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

TERMINATION OF INSURANCE (Effective 1/1/97)

CONTINUATION REQUIRED BY FEDERAL LAW FOR YOU AND YOUR DEPENDENTS

The Continuation Required by Federal Law does not apply to any benefits for loss of life, dismemberment or loss of income.

Federal law enables you or your dependent to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than for gross misconduct). Federal law also enables your dependents to continue health insurance if their coverage ceases due to your death, divorce or legal separation, or with respect to a dependent child, failure to continue to qualify as a dependent. Continuation must be elected in accordance with the rules of your Employer's group health plan(s) and is subject to federal law, regulations and interpretations.

A. Employees and Dependents Continuation Provision

If you and your dependent's insurance would otherwise cease because of a reduction in the number of hours you work or your termination of employment for any reason other than gross misconduct, you or your dependent may continue health insurance upon payment of the required premium to the Employer. You and your dependents must elect to continue insurance within 60 days from the later of: (a) the date of a reduction of your work hours or your termination of employment; or (b) the date notice of the right to continue insurance is sent. Such insurance will not

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be continued by the Company for you and/or your dependents, as applicable, beyond the earliest of the following dates:

- 18 months from the date your work hours are reduced or your employment terminates, whichever may occur first;
- the date the policy cancels;
- the date coverage ends due to your failure to pay the required subsequent premium within 30 days of the due date;
- the date your dependent ceases to qualify as an eligible dependent;
- following enrollment in Medicare; for you, the date you become entitled to Medicare, and for your dependent, the date he becomes entitled to Medicare;
- the effective date of coverage under another group health plan, unless you have a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

TERMINATION OF INSURANCE

CONTINUATION REQUIRED BY FEDERAL LAW FOR YOU AND YOUR DEPENDENTS (Continued)

B. Dependent Continuation Provision

If health insurance for your dependents would otherwise cease because of:

- (1) your death;
- (2) divorce or legal separation; or
- (3) with respect to a dependent child, failure to continue to qualify as a dependent,

such insurance may be continued upon payment of the required premium to the Employer. In the case of (2) or (3) above, you or your dependent must notify your Employer within 60 days of such event. In addition, a dependent must elect to continue insurance within 60 days from the later of: (a) the date the insurance would otherwise cease; or (b) the date notice of the right to continue insurance is sent.

The Company will not continue the health insurance of a dependent beyond the earliest of the following dates:

- 36 months from the date of (1), (2) or (3) above, whichever may occur first;
- the date coverage ends due to failure to pay the required subsequent premium within 30 days of the due date;
- the date the dependent becomes entitled to Medicare, following his/her enrollment in Medicare;
- the date the policy cancels; or
- the date the dependent becomes covered under another group health plan, unless the dependent has a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

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TERMINATION OF INSURANCE

CONTINUATION REQUIRED BY FEDERAL LAW FOR YOU AND YOUR DEPENDENTS (Continued)

C. Subsequent Events Affecting Dependent Coverage

If, within the initial 18-month continuation period, your dependent would lose coverage because of an event described in (1), (2) or (3) of Section B, or because of your coverage loss due to your subsequent entitlement to Medicare, after you have continued your dependent's coverage due to your employment termination or reduction in work hours, your dependent may continue coverage for up to 36 months from the date of loss of your employment or reduction in work hours.

If your employment ends or your work hours are reduced within 18 months after your entitlement to Medicare, your covered dependent may continue coverage for up to 36 months from the date you become entitled to Medicare.

If your employment ends or your work hours are reduced more than 18 months after your entitlement to Medicare, your covered dependent may continue coverage for up to 18 months from the date your employment ends or your work hours are reduced.

Disabled Individuals Continuation Provisions

If you or your dependent is disabled before or within the first 60 days of continuation of coverage which follow termination of employment or a reduction in work hours, the disabled person may continue health insurance for up to an additional 11 months beyond the 18-month period.

The disabled person may also continue the coverage for other family members continuously covered for the initial 18-month continuation period as either the employee covering a dependent, or as the employee's dependents; if they otherwise remain eligible.

To be eligible you or your dependent must:

- a) be declared disabled as of a day before or during the first 60 days of continuation, under Title II or XVI by the Social Security Administration; and
- b) notify the plan administrator of the Social Security Administration's determination within 60 days following the determination and within the initial 18-month continuation period, and provide the plan administrator with a copy of the determination.

TERMINATION OF INSURANCE

CONTINUATION REQUIRED BY FEDERAL LAW FOR YOU AND YOUR DEPENDENTS (Continued)

Termination of coverage for all covered persons during the 29-month period will occur if the disabled person is found by the Social Security Administration to be no longer disabled. Termination for this reason will occur on the first day of the month beginning more than 30 days after the date of the final determination.

All reasons for termination described in sections A and B which apply to the initial 18 months will also apply to any or all covered persons for any additional months of coverage.

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Conversion Available Following Continuation

If you or your dependent's Continuation ends due to the expiration of the maximum 18-, 29- or 36-month continuation period, whichever applies, you or your dependent may be entitled to convert to the insurance in accordance with the Medical Conversion benefit then available to Employees and their dependents.

Interaction with Other Continuation Benefits

A person who is eligible to continue insurance under both (1) and/or (2) below may continue the insurance, upon payment of any required premium, for a period of time not to exceed the longer of: (1) the continuation required by federal law; or (2) any other continuation of insurance provided in this booklet.

Newly Acquired Dependents

If, while your insurance is being continued under the continuation required by federal law provisions, you acquire a new Dependent, such Dependent will be eligible for this Continuation provided:

- the required premium is paid; and
- the Company is notified of your newly acquired dependent in accordance with the terms of the policy.

If event (1) or (2) of Section B should subsequently occur for your newly acquired dependent spouse, such spouse will not be entitled to continue his insurance. However, your dependent child will be able to continue his insurance.

If events described in Section C should subsequently occur for your child who is born, adopted or placed for adoption as a newly acquired dependent, coverage will be continued according to that section.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT OF 1996 (NMHPA)

Your Plan's hospital maternity benefits may not restrict benefits for any hospital length of stay for a mother and her newborn to less than 48 hours following a vaginal delivery and 96 hours following a cesarean section. An attending provider (the doctor or hospital) will not be required to obtain authorization for the minimum length of stay. Earlier discharge is permitted if the decision is made by the attending doctor in consultation with the mother.

Under NMHPA, a health plan may not:

1. Deny enrollment, renewal, or continued coverage to a mother and her newborn based on compliance with this law,
2. Provide money or rebates to mothers to encourage them to request less than the minimum coverage.
3. Offer any incentive to any attending provider to induce that provider to render treatment that is inconsistent with this law,
4. Penalize, reduce or limit an attending provider's reimbursement because the provider rendered treatment in accordance with this law, or
5. Restrict benefits for any portion of the required minimum stay in a manner which is less favorable than the benefits provided for any preceding portion of the stay.

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MENTAL HEALTH PARITY ACT OF 1996 (MHPA)

Your Plan's coverage for mental illness may not impose annual or lifetime dollar limits on mental illness benefits that are different from the limits on medical or surgical benefits, although the plan may continue to use different deductible amounts, co-pays and coinsurance percentages.

Your "combined mental health and nervous conditions, psychiatric disorders, alcoholism and drug addiction" Benefit is changed as follows:

Inpatient - Co-Pay(s) Apply:

30 days per calendar year
60 days per lifetime,

Note: Pre-Admission certification, length of stay review and case management provisions continue to apply.

Outpatient (Under Miscellaneous Expenses) - Annual Deductibles and Co-Pay(s) Apply:

20 visits per calendar year
40 visits per lifetime

If you or your dependents reached the lifetime dollar maximum under the previous limit you will receive no further benefit for mental health, nervous conditions, psychiatric disorders, alcoholism and/or drug addiction.

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